Instructions to Complete the BDS Certification and Enrollment Form

#	Title	Instructions
	General Instructions - Punctuation Marks	Please do <u>not</u> use commas. This moves the data following the comma into the next field when the form is submitted. For example, in an address do not use a comma between the street address and an apartment number.
	Submitting Agency	This should reflect the name of the agency submitting the enrollment form. *Check to make sure this is entered for each form and that it is correct* . This is especially important if you are entering multiple forms on a single log-in because, after the first form, the agency name will <u>not</u> be automatically generated for succeeding forms. You will need to type in your agency name exactly as it appeared on the first form (making sure the Internet address that appears in the field is deleted).
	Print	Clicking on this button will print a hard copy of the enrollment form.
	Contact Us	This button will bring up an e-mail directed to the department's office of information services for questions/comments about the enrollment form/data. Confidential information must not be entered in this e-mail.
1	**Name**	These fields are for the legal name of the person, which includes the full first name, middle initial (if any), last name, and suffix (Sr, Jr, III, IV, V, PhD., etc.).
2	**Mailing Address**	The mailing address of the person should entered here, regardless of whether or not the individual actually lives there (for example, a P.O. box number). If the specific street address is unknown, then "Unknown" should be entered in that space. If the person is homeless and living on the street, then "Homeless" should be entered for the street address and the city/state/country should be entered to the greatest extent possible. If the person is homeless and living at a shelter, enter "Homeless" and the shelter name & address.
3	**DOB**	The person's month, day, and year of birth. The day and month must be entered as a two-digit number; the year as a four-digit number. (mm/dd/yyyy)
4	**Phone #**	The primary telephone number at which the person can be reached, including area code.

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5	**Race**	Racial origins of the person (may be multiple): American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Black/African-American, White, Other Race, or Unknown. This is largely self-identification by the person. Race and Hispanic or Latino origin are considered two separate concepts and therefore Hispanics or Latinos may be of any race or races (US Census Bureau). The U.S. Office of Management and Budget requires this data and defines the five race categories as described below. If the consumer identifies any other race, not listed here, check "Other Race." "Unknown" should be checked only if race cannot be determined.
		American Indian or Alaska Native - A person having origins in any of the original peoples of North and South American (including Central America), and who maintains tribal affiliation or community attachment
		Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
		Black or African American - A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" might be used in addition to "Black" or "African American".
		Native Hawaiian or other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
		White - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa
6	**Ethnicity**	The cultural origins of the person (only one may be selected), <u>regardless of race</u>, are divided into two major categories: Of Hispanic or Latino Origin and Not of Hispanic or Latino Origin. The appropriate sub-category should be determined and checked. Only one subcategory may be selected.
7	**Gender**	Sex of the person, female or male.
8	**Social Security #**	Nine digit unique number issued by Federal government
9	**Guardian Name/Organization**	If the consumer has been found by the court to be incapacitated and a guardian has been appointed, that guardian should be entered here. If the guardian is a private guardian, then contact information related to that guardian should be entered. If the guardianship is with an organization or is a public guardianship (DHHS), then the organization contact information should be reflected as well. Remember that in public guardianships, it is the specific State department that is the public guardian not the employee.
10	**Guardian Mailing Address**	Most recent address of individual or organizational guardian
11	**Guardian Phone #**	Most recent phone number of individual or organizational guardian.

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	Dx Assessment	The Diagnostic Assessment is required prior to the initiation of CSS services, and at least once annually. All five Axes are required.
12	**Axis 1**	DSM-IV-TR Axis 1 primary and secondary Code and Name
13	**Axis 2**	DSM-IV-TR Axis 2 primary and secondary Code and Name
14	**Axis 3**	ICD-9-CM General Medical Conditions Code(s), when possible, and Name(s)
15	**Axis 4**	DSM-IV-TR Axis 4 Names of appropriate Categories - Please select all psychosocial/environmental problem categories that apply:
		Problems with primary support group
		Problems related to the social environment
		Educational problems
		Occupational problems
		Housing problems
		Economic problems
		Problems with access to health care services
		Problems related to interaction with the legal system/crime
		Other psychosocial and environmental problems
16	**Axis 5**	Current GAF Scale Score: _____ (numeric)
17a.	**LOCUS**	Enter numeric LOCUS score.
17b.	**Date of LOCUS**	Date the LOCUS assessment was completed. The day and month must be entered as a two-digit number; the year as a four-digit number. (mm/dd/yyyy)
18	**Date of Dx**	Date the diagnostic assessment was completed The day and month must be entered as a two-digit number; the year as a four-digit number. (mm/dd/yyyy)
19	**Name of Agency**	Name of Agency which employs the Independently Licensed Clinician who conducted the Diagnostic Assessment. If Clinician does not have an agency affliation, please leave blank.
20	**Licensure Level of Clinician**	Specific, current license of Independently Licensed Clinician who conducted the Diagnostic Assessment
21	**Name and Signature of Clinician**	Name of the Independently Licensed Clinician who conducted the Diagnostic Assessment and LOCUS, as well as whether or not the submitting entity has the Diagnostic Assessment with the clinician's signature on it on file.
22	**Agency / Independent Clinician Offering Enrollment - Certification information**	Name of the Agency (if applicable) or Independently Licensed Clinician who is submitting the Enrollment and Certification form to the DHHS Adult Mental Health Program, including Clinician Name, BDS Provider Contract ID #, Agency / Independent Phone #, Address, City / Town, Zip Code

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23	**Name and Phone Number of Person**	Name and Phone Number of Person Completing Enrollment and Certification Form. This will indicate the contact person if the department has questions about information on the form.
24	**Date of Enrollment**	Date Enrollment Form Completed. The day and month must be entered as a two-digit number; the year as a four-digit number. (mm/dd/yyyy)
25	**Certification**	The Certification and Eligibility Section must be completed for all consumers receiving or being referred for services from Community Support Programs.
26	**Insurance**	Indicate any and all types of health insurance programs in which the consumer is enrolled and complete the requested information for them. Please provide the MaineCare and Medicare numbers for consumers in these programs. If the person is not enrolled in either program or the status is unknown, enter NONE or UNKNOWN as appropriate for the number. If the consumer has other private insurance, please enter only the name of the Insurer.
27	**Services - Current**	Check all services that apply. Indicate the provider name and start date of each service with the day and month entered as a two-digit number; the year as a four-digit number. (mm/dd/yyyy)
28	**Annual ISP Date**	For Consumers who are "Currently in Service," indicate the annual ISP date. The day and month must be entered as a two-digit number; the year as a four-digit number. (mm/dd/yyyy)
29	**Services - New**	Check CSS if the Diagnostic Assessment and LOCUS score indicate that the consumer meets criteria for Community Support Services. Check RS (PNMI) if the consumer requires any level of Private Non-Medical Institution (PNMI) Services as defined in theMaineCare Manual, Chapter II, Section 07.
30	**Referral Information**	Enter agency name under the appropriate CSS and/or RS (PNMI) column . Check appropriate circles to describe referral information.
31	**ISP date (projected)**	For Consumers "New To Services", indicate the projected date the initial ISP will be completed. The day and month must be entered as a two-digit number; the year as a four-digit number. (mm/dd/yyyy)
	Print	This is another opportunity to print the form: Clicking on this button will print a hard copy of the enrollment form.

Submit	Clicking on this button will submit the data on this form to the department. A pop-up will remind you to be sure that you have printed a copy of the form. If you have not and you want a paper copy, click on the *OK* button -- this will both print and submit the form. If you have already printed the form and just want to submit it, click on the the *Cancel* button -- this automatically takes you back into the Submit Only mode and will submit the information.
Reset	If, for any reason, you want to clear the whole form and start again, click on this button.